ECONOMIC AFFAIRS IC October 5, 2011 EXHIBIT 19

MEDICAL STATUS FORM This form is intended to: 1) facilitate communication between a worker with a work-related injury or occurrence employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work; and 2) provide necessary medical provider for Stay at Work/Return to Work at Work at Work/Return to Work at Work/Return to Work at Work at Work at Work at Wor

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Patient/ Employee Info	Date of Injury (mm/dd/yyyy) Date of Next Visit			Date of Birth (mm/dd/yyyy) Claim Administrator Number							aiiri C	are Provider i	vame &	Address	
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— Ш			wring (Note: Temporary, alternative and full duty return												
	Please sel	ect ONE of the fo	llowir	ig: (Note	e - Te	emporary.	alternat	ive and	full duty re	eturn c	dates :	are subject to	reasse	ssment).	
ork?	Condition Uncha			-											
or W	Patient/Employee Released to Full Duty										Effe	ctive Date			
Released for Work?	Patient/Employee Released to Modified Duty (SEE WORK ABILI										Effe	ctive Date			
ease				findings indicate worker should remain off work							Effe	ctive Date			
Re	> Anticipated date	oye	oyee can perform temporary alternate work							Antic	cipated Date				
		oye	byee can return to full duty							Antic	ipated Date)			
	Total Number of Hours/Day Patient/ Employee May Work:			Number of Hours							NR = Nat Restricted Patient/Employee				
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A -	Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? No Yes If Yes, please explain Will the patient/employee be required to use any devices or braces? No Yes If Yes, please explain														
A	dditional comments spec	cific to patient/e	mplo	yee's w	ork a	abilities									
С	an the patient/employee	return to work a	at tim	ne of inju	ury o	ccupatio	n?	□N¢	Ye Ye	s					
Par	tient/Employee Signature		Date												
Signatures	Health Care Provider's Signature						Date					M	edical S	tatus Form 9/19/11	
	This section	on contains p	rivat	te infor	mat	ion for t	he ME	DICA	L PROVI	DER	, INS	URER AN	D		
PATIENT/EMPLOYEE ONLY and is NOT to be given to EMPLOYER															
agnosed Condition															
eatment plan to increase functional improvement until next appointment															
entity of	medication prescribed			-											
ticipate	d MMI date	Ac	tual I	MMI dat	te				Perm W	P Imp	airm	ent Rating		%	

MEDICAL STATUS FORM This form is intended to: 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical status to the insurer Patient/Employee Name (Last, First) Timestamp for Health Care Pr Clear Form re Providers Health Care Provider Name & Address Patient/ Date of Injury (mm/dd/yyyy) Date of Birth (mm/dd/yyyy) Provider Date of Next Visit Claim Administrator Number Condition Unchanged from Last Report Released for Work? Patient/Employee Released to Full Duty **Effective Date** Patient/Employee Released to Modified Duty (SEE WORK ABILITIES) Effective Date Time Loss Authorized - objective findings indicate worker should remain off work **Effective Date** > Anticipated date patient/employee can perform temporary alternate work Anticipated Date Description Anticipated date patient/employee can return to full duty Anticipated Date Total Number of Hours/Day Patient/ Employee May Work Patient/Employee Should / Must NR 5 Sit / Stand / Walk Every _days per week 2 Stand 0 1 6 NR _hours per day 0 1 2 3 4 5 6 8 NR Walk hours Occasionally Frequently Continuously Permanent Never Upon MMI OCCASIONALLY : CONTINUOUSLY : Hand/Wrist Work ☐L ☐R ☐B Grasping LRB Pushing/Pulling L R B Fine Manipulation L R B Reaching LRB Bending \Box П \Box \Box П Kneeling Squatting Climbing Lifting 01-10 lbs. Lifting 11-20 lbs. Lifting 21-25 lbs. Lifting 26-50 lbs. Lifting 51-70 lbs. Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? No Yes If Yes, please explain Will the patient/employee be required to use any devices or braces? No Yes If Yes, please explain Additional comments specific to patient/employee's work abilities

This page is for PATIENT/EMPLOYEE and EMPLOYER

☐No ☐Yes

Medical Status Form 9/19/11

Date

Date

Can the patient/employee return to work at time of injury occupation?

Patient/Employee Signature

Health Care Provider's Signature